U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 13 May 2004

Case No.: 2002-BLA-5487

In the Matter of:

LELON D. STROUD,
Claimant

v.

KINDILL MINING, INC.,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

BEFORE: Robert L. Hillyard
Administrative Law Judge

DECISION AND ORDER - DENIAL OF BENEFITS

This proceeding arises from a claim filed by Lelon D. Stroud for benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901, *et seq.*, as amended ("Act"). In accordance with the Act, and the regulations issued thereunder, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a formal hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of persons who were totally disabled at the time of their death or whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising out of coal mine employment, and is commonly known as black lung.

A formal hearing in this case was scheduled in Evansville, Indiana on December 11, 2003. On December 3, 2003, the parties filed a Joint Motion to Vacate Hearing and Decide the Case on the Record, which was granted by Order dated December 4, 2003. Each of the parties was afforded full opportunity to present evidence and argument as provided in the Act and the regulations

issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

The findings and conclusions that follow are based upon a careful analysis of the entire record in light of the arguments of the parties, applicable statutory provisions, regulations, and pertinent case law. The parties requested that the hearing be cancelled and a decision made on the existing record. The request for decision on the record was granted.

I. Statement of the Case

The Claimant, Lelon D. Stroud, filed a claim for black lung benefits pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, on June 29, 2001 (DX 1).[1] A Notice of Claim was issued on July 30, 2001, identifying Kindill Mining, Inc., as the putative responsible operator (DX 19). On October 2, 2001, the Employer filed its Response to Notice of Claim (DX 32). The District Director, OWCP, made an initial determination of nonentitlement (DX 28). The Claimant requested a formal hearing and the claim was referred to the Office of Administrative Law Judges on September 10, 2002 (DX 33).

A hearing was scheduled in Evansville, Indiana on December 11, 2003, before the undersigned Administrative Law Judge. At the request of the parties, the hearing was cancelled and this case is to be decided on the record. *See* December 4, 2003 Order. By Order dated February 13, 2004, the record was held open until February 23, 2004 for the filing of briefs.

II. Issues[2]

The controverted issues as listed on Form CM-1025 are as follows:

1. Whether the Miner has pneumoconiosis as defined by the Act and the regulations;

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[1] In this Decision, "DX" refers to the Director's Exhibits, "CX" refers to the Claimant's Exhibits, and "EX" refers to the Employer's Exhibits.

[2] In an Agreed Order Amending Issues in Controversion, the Employer withdrew the issue of responsible operator and the issues contained in paragraph 18 relating to responsible operator (DX 35).

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

3. Whether the Miner is totally disabled;

4. Whether the Miner's disability is due to pneumoconiosis;

5. Whether the Claimant has dependents for purposes of augmentation of benefits; and,

6. The remaining issues set forth in paragraph 18, as well as the issues as to constitutionality of the Act and its regulations, are preserved for appeal purposes.

III. Findings of Fact and Conclusions of Law

The Claimant, Lelon D. Stroud, was born on May 28, 1942 (DX 1). He completed the 12th grade (DX 1). The Claimant has two dependents for purposes of augmentation of benefits; namely, his wife, Linda (Sharber) Stroud, whom he married on October 16, 1961 (DX 1, 7), and a disabled, adult daughter, Kathy Lynn Stroud, born on November 30, 1964 (DX 1, 8).

The Miner's smoking history varies within the record. Dr. Shashikumar noted a 20 pack year habit (CX 1). Dr. Houser noted 32 years at a rate of one pack per day quitting in 2000 (DX 11). Dr. Tuteur, in the most comprehensive review of the record, noted a 30+ year smoking history at a rate of one pack per day quitting in 2000. I afford great weight to Dr. Tuteur's thorough examination of the record on this issue and find that the Claimant has a smoking history of 30+ years at a rate of one pack of cigarettes per day quitting in 2000.

Coal Mine Employment

The determination of length of coal mine employment must begin with § 725.101(a)(32)(ii), which directs an adjudication officer to ascertain the beginning and ending dates of coal mine employment by using any credible evidence.

On his application, the Claimant stated that he worked in coal mine employment for 23 years (DX 1). The Employer does not contest the length of coal mine employment.

The 23 years of coal mine employment listed on the Miner's application is supported by the Claimant's Employment History form (DX 2, 3) and the Claimant's FICA earnings worksheet

(DX 6). I find that the Claimant has established 23 years of coal mine employment. On his Employment History, the Claimant stated that over the relevant period he was a stagger man, a coal haul driver, and a utility man (DX 3).

The Claimant's last employment was in the State of Indiana; therefore, the law of the Seventh Circuit is controlling.

Responsible Operator

Kindill Mining, Inc., has withdrawn it's challenge to the issue of responsible operator, and I find that Kindill Mining, Inc., is properly named as responsible operator pursuant to §§ 725.494 and 725.495 (DX 35).

IV. Medical Evidence

X-ray Studies

	Date	Exhibit	Doctor	Reading	Standard
1.	09/07/01	DX 27	McGraw B reader[3] Board cert.[4]	0/0	Good
	Comments:	Evidence of previous sternotomy and cardiac bypass surgery; few small calcified granulomas, not the type associated with pneumoconiosis; no radiographic evidence of pneumoconiosis.			
2.	09/07/01	DX 27	Wiot B reader Board cert.	0/0	Good
	Comments:	No evidence of coal workers' pneumoconiosis; previous coronary by-pass surgery.			
3.	09/07/01	DX 27	Tuteur	0/0	Good
	Comments:	s/p median sternotomy; borderline cardiomegaly; ecstatic thoracic aorta; old healed calcified granulomatous disease.			

[3] A "B reader" is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services. *See* 42 C.F.R. § 37.51(b)(2).

[4] A Board-certified Radiologist is a physician who is certified in Radiology or Diagnostic Roentgenology by the American Board of Radiology or the American Osteopathic Association. *See* § 718.202(a)(ii)(C).

4.	09/07/01	DX 16	Whitehead B reader Board cert.	1/0	Good

Comments: "nodular and linear opacities are noted in the mid lung fields compatible with mild changes of pneumoconiosis; prior CABG."

5.	09/07/01	DX 14	Gaziano B reader	Quality only	Good

Pulmonary Function Studies

	Date	Exh.	Doctor	Age/Hgt.	FEV_1	MVV	FVC	Standards
1.	09/07/01	DX 13	Houser	59/70"	3.10	N/A	4.16	Tracings included. Good coop./ comp.

Arterial Blood Gas Studies

	Date	Exhibit	Physician	pCO_2	pO_2
1.	09/07/01	DX 12	Houser	39.2	69.2

Narrative Medical Evidence

1. Dr. William Houser, who lists no medical specialty credentials, examined the Claimant on September 7, 2001 (DX 11). Based on symptomatology (sputum, wheezing, dyspnea, cough, chest pain, ankle edema), employment history (23 years, welder), individual and family histories (high blood pressure, heart disease, diabetes, emphysema), smoking history (1967 to 2000, 1 ppd), physical examination (clear to percussion, few rales at bases), chest x-ray (1/0), pulmonary function study (normal), arterial blood gas study (mild hypoxemia), and an EKG, Dr. Houser diagnosed:

> 1. coal workers' pneumoconiosis category 1/0 – based on history of coal mine employment for approximately 23 years and the chest roentgenographic findings; 2. Chronic bronchitis with small airway obstruction – based on history of chronic cough with sputum production and decreased airflow at 75% forced vital capacity consistent with small airway obstruction; 3. Arteriosclerotic heart disease status post coronary bypass – based on history of prior treatment; 4. Sternal dehiscence – based o[n] prior treatment and physical exam.

Dr. Houser listed the etiology of the coal workers' pneumoconiosis as 23 years exposure to coal and rock dust; he listed the etiology of the chronic bronchitis as cigarette smoking and exposure to coal and rock dust; he listed the etiology of hypertension and arteriosclerotic heart disease as mainly hereditary; he listed the etiology of sternal dehiscence as secondary to coronary bypass surgery, but he opined that the underlying chronic lung disease contributed to the development of this condition. Dr. Houser opined that Mr. Stroud's impairment is severe and would preclude coal mine employment. He opined, however, that the Miner's coal workers' pneumoconiosis presented a minimal "if any" contribution to the total disability. He stated that the heart disease was the major contributor to Mr. Stroud's disability.

2. Dr. Anthony V. Zancanaro, a Board-certified Radiologist and a B reader, reviewed a February 11, 2003 CT study performed on the Claimant (EX 1). Dr. Zancanaro noted a few short, peripheral linear opacities, which he considered to be within normal limits. He noted a calcified granuloma in the right lung. No fibrotic masses were detected, and Dr. Zancanaro saw "no evidence of interstitial infiltrates or interstitial scarring or any significant interstitial density" which would be typical of coal workers' pneumoconiosis.

3. Dr. R.H. Shashikumar, who lists no medical specialty credentials, examined the Claimant on February 14, 2003 (CX 1). Based on symptomatology (cough, sputum, dyspnea, and wheezing), employment history (strip mine, 21 years), individual and family histories (high blood pressure, diabetes, coronary artery disease, congestive heart failure), smoking history (20 pack years), physical examination (moderately obese, emphysematous chest, moderate bilateral air entry, no wheeze), and pulmonary function study (very severe obstructive pattern without bronchodilator response), Dr. Shashikumar diagnosed dyspnea with underlying COPD. He was noncommittal on the etiology of these conditions, stating that the symptoms viewed "could be secondary to emphysema, however, other conditions such as interstitial lung diseases and pulmonary vascular diseases need to be considered." He stated that, "I cannot entirely rule out the presence of interstitial lung disease…."

4. Dr. Peter G. Tuteur, a Board-certified Internist and Pulmonologist, performed a records review at the request of the Employer (DX 27, pp. 18-35). Dr. Tuteur reviewed extensive hospital records dating from 1985 through 2001. He noted the Miner's employment (23 years, welder) and smoking histories (30+ years, one pack per day). He noted a past history of coronary artery disease, hypertension, hyperlipidemia, and peripheral

vascular disease. The records reviewed showed minimal symptoms, physical examinations of the chest were routinely normal. Objective testing data through 2001 was nearly normal for pulmonary function, arterial blood gas and x-ray results. He opined that the lone positive x-ray reading by Dr. Whitehead was effectively refuted by a negative July 29, 1997 CT scan. "Based on a careful review of all of this information, the most significant problems adversely affecting the health status of Mr. Stroud are those of the cardiovascular variety including advanced coronary artery disease …, hypertension …, [and] advanced peripheral vascular disease." "In essence, despite coal mine dust exposure and despite aggressive cigarette smoke exposure, pulmonary functions were essentially normal through at least November, 1997 and probably beyond." He opined that Mr. Stroud does not have simple coal workers' pneumoconiosis of sufficient profusion and severity to cause clinical symptoms, physical examination abnormalities, impairment of pulmonary function, or alteration of chest radiographic images. He opined that Mr. Stroud "is significantly and permanently and totally disabled from returning to work as a coal miner or work even approaching similar effort … due to coronary artery disease, arteriosclerotic heart disease, peripheral vascular disease and its treatment and sequelae." "None of these conditions were in any way related to, aggravated by, or caused by the inhalation of coal mine dust or the development of coal workers' pneumoconiosis."

Hospitalization Records

The record contains 1,313 pages of treatment notes and hospitalization records (DX 26). In the Employer's submitted Evidence Summary form, Kindill Mining's counsel cites to 33 pages of issue-specific notes for review.[5] The notes cited date from May 6, 1991 through June 18, 2001, and consistently document diagnoses of chronic obstructive pulmonary disease, hypertension, and coronary artery disease. The notes consistently document the Miner's 30-year cigarette smoking habit and list a 1996 triple coronary artery bypass surgery. There is no diagnosis of pneumoconiosis in the notes cited nor is the etiology of any of the conditions listed in the records reviewed.

[5] See Employer's Black Lung Evidence Summary form, citing to (DX 26) pages MR 10, 11, 12, 15, 16, 17, 19, 20, 24, 34, 64, 67, 72, 79, 96, 103, 105, 107, 113, 114, 119, 143, 147, 170, 173, 174, 180, 231, 317, 409, 436, 488.

V. Discussion and Applicable Law

The Claimant filed his black lung benefits claim on June 29, 2001 (DX 1). Because this claim was filed after March 31, 1980, the effective date of Part 718, it must be adjudicated under those regulations.[6]

In order to establish entitlement to benefits in a living miner's claim pursuant to 20 C.F.R. § 718, a claimant must establish that he suffers from pneumoconiosis, that the pneumoconiosis arose out of coal mine employment, and that the pneumoconiosis is totally disabling. *See* 20 C.F.R. §§ 718.3, 718.202, 718.203, 718.204; *Peabody Coal Co. v. Hill*, 123 F.3d 412, 21 B.L.R. 2-192 (6th Cir. 1997); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986) (*en banc*).

Section 718.202 provides four means by which pneumoconiosis may be established. Under § 718.202(a)(1), a finding of pneumoconiosis may be made on the basis of x-ray evidence. The record contains four interpretations of one chest x-ray dated September 7, 2001. Dr. Gaziano reviewed the September 7, 2001, x-ray film for quality only, and he rated the film quality as good.

The Board has held that an Administrative Law Judge is not required to defer to the numerical superiority of x-ray evidence, *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-65 (1990), although it is within his or her discretion to do so, *Edmiston v. F&R Coal Co.*, 14 B.L.R. 1-65 (1990). However, "administrative factfinders simply cannot consider the quantity of evidence alone, without reference to a difference in the qualifications of the readers or without an examination of the party affiliation of the experts." *Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993).

Interpretations of B readers are entitled to greater weight because of their expertise and proficiency in classifying x-rays. *Vance v. Eastern Assoc. Coal Corp., Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985); 8 B.L.R. 1-68 (1985). Physicians who are Board-certified Radiologists as well as B readers may be accorded still greater weight. *Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993).

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[6] Amendments to the Part 718 regulations became effective on January 19, 2001. Section 718.2 provides that the provisions of § 718 shall, to the extent appropriate, be construed together in the adjudication of all claims.

The September 7, 2001 x-ray was read as negative by three physicians, Drs. McGraw and Wiot, both Board-certified Radiologists and B readers, and Dr. Tuteur, who presents no specialty credentials in the interpretation of x-rays. The x-ray was read as positive by Dr. Whitehead, a Board-certified Radiologist and a B reader. I give greater weight to the combined readings of Drs. McGraw, Wiot, and Tuteur over the one reading of Dr. Whitehead, and find that the x-ray evidence is negative for pneumoconiosis. I find that the existence of pneumoconiosis has not been established pursuant to 20 C.F.R. § 718.202(a)(1).

Section 718.202(a)(2) is inapplicable because there are no biopsy or autopsy results. Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of the several presumptions are found to be applicable. In the instant case, § 718.304 does not apply because there is no x-ray, biopsy, autopsy, or other evidence of large opacities or massive lesions in the lungs. Section 718.305 is not applicable to claims filed after January 1, 1982. Section 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982.

Under § 718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. Pneumoconiosis is defined in § 718.201 as a chronic dust disease of the lung, including respiratory or pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.

> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and

> its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

Section 718.201(a).

For a physician's opinion to be accorded probative value, it must be well reasoned and based upon objective medical evidence. An opinion is reasoned when it contains underlying documentation adequate to support the physician's conclusions. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which the diagnosis is based. *Id.* A brief and conclusory medical report which lacks supporting evidence may be discredited. *See Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); *see also, Mosely v. Peabody Coal Co.*, 769 F.2d 357 (6th Cir. 1985). Further, a medical report may be rejected as unreasoned where the physician fails to explain how his findings support his diagnosis. *See Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

Dr. Zancanaro, a Board-certified Radiologist and a B reader, reviewed a February 11, 2003 CT study and saw "no evidence of interstitial infiltrates or interstitial scarring or any significant interstitial density" which would be typical of coal workers' pneumoconiosis. The Department of Labor has rejected the view that a CT scan, by itself, "is sufficiently reliable that a negative result effectively rules out the existence of pneumoconiosis." 65 Fed. Reg. 79, 920, 79, 945 (Dec. 20, 2000). Therefore, a CT scan, while arguably the most sophisticated and sensitive test available, must still be measured and weighed based upon the radiological qualifications of the reviewing physician. *Consolidation Coal Co. v. Director, OWCP [Stein],* 294 F.3d 885 (7th Cir. 2002). Dr. Zancanaro is a Board-certified Radiologist and a B reader. Noting Dr. Zancanaro's superior credentials, I afford Dr. Zancanaro's opinion substantial weight against a finding of pneumoconiosis.

Dr. Shashikumar, who lists no medical specialty credentials, diagnosed chronic obstructive pulmonary disease and dyspnea. He was noncommittal on the etiology of these conditions, stating that the symptoms viewed "could be secondary to emphysema, however, other conditions such as interstitial lung diseases and pulmonary vascular diseases need to be considered." He stated that, "I cannot entirely rule out the presence of interstitial lung disease…." Dr. Shashikumar's opinion is not well reasoned. A physician's opinion may be given

little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) (treating physician's opinion entitled to little weight where he concluded that the miner "probably" had black lung disease); *see also, Justice v. Island Creek Coal Co.*, 11 B.L.R 1-91 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R 1-236 (1984).

Dr. Shashikumar does not diagnose coal workers' pneumoconiosis. He does diagnose chronic obstructive pulmonary disease, which could form the basis of a legal pneumoconiosis diagnosis, but he fails to affirmatively tie that condition to the Miner's coal mine employment. As his etiology of the diagnosed COPD is equivocal and vague, his possible legal pneumoconiosis diagnosis must fail. Noting Dr. Shashikumar's lack of medical specialty credentials and the equivocal and vague nature of his diagnosis, I find Dr. Shashikumar's opinion unsupported and unreasoned and I afford it less weight.

Dr. Tuteur, A Board-certified Pulmonary Specialist and Internist, was a nonexamining physician. A nonexamining physician's opinion may constitute substantial evidence if it is corroborated by the opinion of an examining physician or by the evidence considered as a whole. *Newland v. Consolidation Coal Co.*, 6 B.L.R. 1-1286 (1984). Dr. Tuteur reviewed employment history, smoking history, physical examination results, pulmonary function tests, arterial blood gas readings, x-ray interpretations, and hospital records dating from 1985 through 2001. Dr. Tuteur opined that Mr. Stroud does not have simple coal workers' pneumoconiosis as evidenced by the lack of clinical symptoms, physical examination abnormalities, impairment of pulmonary function, or alteration of x-ray images. He opined that the symptoms and ailments plaguing the Miner were the result of cardiovascular problems and not a result of coal mine employment.

Dr. Tuteur utilized the objective evidence on record to opine that the Miner does not suffer from pneumoconiosis. His findings are supported by the evidence as a whole. Noting Dr. Tuteur's superior pulmonary qualifications, I afford his opinion substantial weight in support of no pneumoconiosis.

Dr. William Houser, who lists no medical specialty credentials, based his diagnosis on symptomatology, employment history, smoking history, family and individual medical histories, physical examination, chest x-ray, pulmonary function study, and arterial blood gas study. Based on the information gathered, Dr. Houser diagnosed coal workers' pneumoconiosis and chronic bronchitis with small airway obstruction. He listed the etiology of pneumoconiosis as 23 years of coal dust exposure and

chest x-ray findings; he listed the etiology of the chronic bronchitis as cigarette smoking and exposure to coal dust.

Dr. Houser diagnosed "coal worker's pneumoconiosis category 1/0 – based on history of coal mine employment for approximately 23 years and the chest roentgenographic findings." The Board holds permissible the discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993) (*citing Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-405 (1985)). In *Taylor*, the Board explained that the fact that a miner worked for a certain period of time in the coal mines alone "does not tend to establish that he does [or does] not have any respiratory disease arising out of coal mine employment." *Taylor*, 8 B.L.R. at 1-407. When a doctor relies solely on a chest x-ray and a coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray … and not a reasoned medical opinion." *Id.* Further, it is proper to accord less weight to a physician who relied upon an x-ray that has been discredited by the Administrative Law Judge. *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*). Dr. Houser relied upon the positive x-ray interpretation of Dr. Whitehead. That reading has been refuted by the combined readings of Drs. McGraw, Wiot, and Tuteur. I find that Dr. Houser's diagnosis of coal workers' pneumoconiosis is unsupported by the record and I afford it less weight.

Dr. Houser also diagnosed chronic bronchitis due to cigarette smoking and coal dust exposure. Such a diagnosis meets the statutory definition of legal pneumoconiosis under § 718.201(a)(2). Dr. Houser based his diagnosis on symptomatology of chronic cough with sputum production and a decreased airflow at 75% forced vital capacity. Dr. Houser noted the Miner's employment (23 years, welder) and smoking (1967 to 2000, 1 ppd) histories, and opined that a combination of cigarette smoke and coal and rock dust created the chronic condition. I find Dr. Houser's legal pneumoconiosis diagnosis is supported by the record. Noting Dr. Houser's lack of medical specialty credentials, however, I afford his legal pneumoconiosis diagnosis less weight than the better documented opinion of Dr. Tuteur, a Pulmonary Specialist.

The hospital records are nonsupportive of a pneumoconiosis finding. There is no direct diagnosis of coal workers' pneumoconiosis in the records. Although treatment notes consistently document chronic obstructive pulmonary disease,

there is no mention in the notes of the disease being related to, contributed to, or aggravated by coal dust exposure or coal mine employment. As such, the treatment notes and hospitalization records do not support either a clinical or a legal pneumoconiosis diagnosis.

Taken as a whole, Dr. Tuteur, a Board-certified Internist and Pulmonologist, provides a well-reasoned opinion, based upon objective medical evidence, that the Claimant does not suffer from pneumoconiosis as defined in § 718.201. This determination is reinforced by the dually certified negative interpretation by Dr. Zancanaro of the February 1, 2003 CT scan. The opinion of Dr. Shashikumar is unreasoned. The possible legal pneumoconiosis diagnosis by Dr. Houser, who lists no medical specialty credentials, is outweighed by the better credentialed opinions of Drs. Tuteur and Zancanaro. Accordingly, I find that the Claimant has not established the existence of pneumoconiosis under § 718.202(a)(4).

Causal Connection

Because the Claimant has not established pneumoconiosis, the question of whether it is caused by his coal mine employment is moot. Moreover, even though the evidence establishes more than 10 years of coal mine work, any presumption of a causal connection with coal mine employment is more than adequately rebutted by the medical opinion evidence discussed above. Therefore, the evidence fails to establish this element of the claim.

Total Disability

Since the Miner does not have pneumoconiosis, his claim cannot succeed. In any event, had he established the existence of the disease, the evidence does not show that he had a totally disabling respiratory or pulmonary ailment which could be attributed to pneumoconiosis. Total disability is defined as the miner's inability, due to a pulmonary or respiratory impairment, to perform his or her usual coal mine work or engage in comparable gainful work in the immediate area of the miner's residence. Section 718.204(b)(1)(i) and (ii). The Claimant must establish by a preponderance of the evidence that his pneumoconiosis was at least a contributing cause of his total disability. *See, e.g., Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994). Total disability can be established pursuant to one of the four standards in § 718.204(b)(2) or through the irrebuttable presumption of § 718.304, which is incorporated into § 718.204(b)(1). The presumption is not

invoked here because there is no x-ray evidence of large opacities and no biopsy or equivalent evidence.

Where the presumption does not apply, a miner shall be considered totally disabled if he meets the criteria set forth in § 718.204(b)(2) in the absence of contrary probative evidence. The Board has held that under § 718.204(c), the precursor to § 718.204(b)(2), all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231, 1-232 (1987).

Section 718.204(b)(2)(i) permits a finding of total disability when there are pulmonary function studies with FEV_1 values equal to or less than those listed in the tables and either:

1. FVC values equal to or below listed table values; or,
2. MVV values equal to or below listed table values; or,
3. A percentage of 55 or less when the FEV_1 test results are divided by the FVC test results.

The record contains one pulmonary function study, the results of which exceed the disability standard under the Act. Dr. Tuteur reviewed the test (as a nonexamining physician) and found no evidence of respiratory impairment caused by coal mine dust.

Total disability may be found under § 718.204(b)(2)(ii) if there are arterial blood gas studies with results equal to or less than those contained in the tables. The record contains one arterial blood gas study which resulted in values in excess of the disability standard.

There is no evidence presented, nor do the parties contend that the Claimant suffers from cor pulmonale or complicated coal workers' pneumoconiosis.

Under § 718.204(b)(2)(iv) total disability may be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine work or comparable and gainful work. There are two medical narratives in the record discussing the Claimant's impairment level. Drs. Zancanaro and Shashikumar made no diagnosis as to

disability. Therefore, their opinions can be given no probative weight on this issue.

Dr. Houser, who presents no medical specialty credentials, opined that Mr. Stroud's impairment is severe and that it would preclude future coal mine employment. Noting normal pulmonary function testing and arterial blood gas studies showing only mild hypoxemia, however, he opined that the Miner's diagnosed pneumoconiosis presented a minimal "if any" contribution to the Miner's disability. He stated that heart disease was the major contributor to Mr. Stroud's disability. The Seventh Circuit requires that pneumoconiosis be a "simple contributing cause" of the miner's total disability. *Hawkins v. Director, OWCP*, 907 F.2d 697, 707 (7th Cir. 1990); *Shelton v. Director, OWCP*, 899 F.2d 690, 693 (7th Cir. 1990). However, an equivocal opinion regarding etiology may be given less weight. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988). Dr. Houser listed pneumoconiosis as contributing, minimally "if any" to the Miner's total disability. His opinion as to causality is equivocal. Because of his equivocal opinion and his lack of medical specialty credentials, I give Dr. Houser's opinion less weight as to disability.

Dr. Tuteur, a Board-certified Internist and Pulmonologist, opined that Mr. Stroud "is significantly and permanently and totally disabled from returning to work as a coal miner … due to coronary artery disease, arteriosclerotic heart disease, peripheral vascular disease and its treatment and sequelae." "None of these conditions were in any way related to, aggravated by, or caused by the inhalation of coal mine dust…." He bases his opinion on a record review of pulmonary function studies, arterial blood gas readings, minimal recorded symptoms, and physical examinations which consistently showed normal chest functions.

Dr. Tuteur utilized the objective data of record to support his finding that the Miner is totally disabled by coronary-related ailments unrelated to the Miner's exposure to coal mine dust. I find his opinion well reasoned. Noting Dr. Tuteur's superior credentials, I afford Dr. Tuteur's opinion substantial weight in support of a finding that the Claimant's disability did not arise out of coal mine employment.

As a result of the nonqualifying pulmonary testing, normal blood gas testing, and the well-reasoned opinion of Dr. Tuteur that the Claimant's disability did not arise out of coal mine employment, I find the Claimant has failed to establish total disability due to pneumoconiosis arising out of coal mine work under § 718.204(b)(2).

VI. Entitlement

Lelon D. Stroud, the Claimant, has not established entitlement to benefits under the Act.

VII. Attorney's Fee

The award of an attorney's fee is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the claim.

VIII. ORDER

It is, therefore,

ORDERED that the claim of Lelon D. Stroud for benefits under the Act is hereby DENIED.

A

Robert L. Hillyard
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C., 20013-7601. A copy of a Notice of Appeal must also be served upon Donald S. Shire, Esq., 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.